Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report#: HL408838702M
Compliance #: HL408831823C

Date Concluded: May 18, 2026

Name, Address, and County of Licensee Investigated:
Caretta Senior Living
1910 County Road C East
Maplewood, MN 55109
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to administer insulin as ordered and the resident was hospitalized for high blood sugar.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident experienced high blood sugars with hospitalization and diagnoses of an infection. After hospitalization, the facility had a transcription error that resulted in the resident having both long-acting and short-acting insulin administered close to the same time, resulting in a low blood sugar. Because the investigation could not determine who the resident's primary care provider was, it was unknown if the decrease in insulin order was a result of the low blood sugar or due to the facility's limitations to providing sliding scale (dose based on blood sugar results). Additionally, the facility failed to monitor the resident's blood sugar for two days prior to the second hospitalization, aside from one blood sugar reading that was high, but not a

medical emergency. Therefore, the lack of other blood sugar readings was undetermined if it indicated a need for the resident to be sent to the hospital sooner.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted a medical provider and a family member. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares while on site.

The resident resided in an assisted living memory care unit. The resident's diagnoses included type 1 diabetes, high blood pressure, high cholesterol, and history of stroke. The resident's service plan included assistance with medication administration, blood sugar monitoring, and safety checks. The resident's assessment indicated the resident walked with a walker and was oriented to person, place and time.

The resident's insulin orders indicated he received short-acting insulin, 10 units, three times per day before meals and an order to give an additional 2 units if the resident's blood sugar was above 250. The insulin orders also included an order for long-acting insulin at bedtime.

Progress notes indicated the resident started to have higher blood sugar readings, with the need for the additional 2 units of insulin, a few days prior to his first hospitalization. The resident experienced a fall, and his blood sugar readings were between 564 to 600. The facility sent the resident to the hospital. He returned the next day with new orders [for an antibiotic].

Two days later, the resident's progress notes indicated he had an elevated blood sugar of 493, received the additional 2 units of insulin but was shaking. Staff called 911. His blood sugar rose to 571 when emergency medical services arrived and transported him to the hospital.

The resident's hospital notes indicated the resident was diagnosed with a urinary tract infection. He returned to the facility two days later with orders for an antibiotic and new insulin orders. The hospital decreased the resident's short-acting insulin from 10 units to 7 units with sliding scale orders (additional units based on blood sugar readings) to be given before meals.

Progress notes indicated the resident returned to the facility in the afternoon. The nurse contacted the resident's provider upon return from the hospital to inform the facility was unable to provide sliding scale insulin and the provider agreed to update the order.

The resident's medication administration record (MAR) indicated the resident received the previous short-acting insulin of 10 units prior to supper. Then the resident's MAR reflected the insulin order changes transcribed in error, to provide the shorting-insulin of 7 units at 8:00 p.m. scheduled to start the next day. The resident MAR's indicated unlicensed personnel (ULP) administered the short-acting insulin at 8:00 p.m. and the scheduled long-acting insulin at 9:00

p.m. The last blood sugar reading taken that day was at 2:05 p.m., with a blood sugar reading of 196. Staff failed to take a blood sugar reading at supper or bedtime.

Progress notes indicated the next morning at 4:36 a.m., the resident had a low blood sugar reading of 57 (normal is generally between 70 to 130). As directed by the nurse, staff provided juice and monitored the resident's blood sugar when it returned to normal, 144, at 6:00 a.m.

The MAR indicated staff failed to monitor the resident's blood sugar the rest of the day including at meals prior to insulin administration and at bedtime. Additionally, the resident's short-acting insulin was updated to reflect the decrease of insulin from 10 units to 7 units with the correct administration times at 8:00 a.m., noon, and 5:00 p.m.

Progress notes indicated the next morning, at 7:25 a.m., ULP notified the nurse the resident was crawling on the floor and his blood sugar was 501. The nurse encouraged staff to provide his morning insulin per order, encourage water and recheck the blood sugar.

Staff failed to recheck the resident's blood sugar and failed to complete any scheduled blood sugar checks at 8:00 a.m. and noon. The MAR indicated at 5:00 p.m., the resident's blood sugar was 350 when given the 5:00 p.m. scheduled dose of short-acting insulin. The MAR indicated staff failed to administer the resident's long-acting insulin scheduled at 9:00 p.m. and failed to complete the resident's bedtime blood sugar check.

Progress notes indicated the next morning, at 3:00 a.m., the resident's blood sugar reading was higher than the glucometer, giving a "high" reading. ULP contacted the nurse and instructed them to push fluids and recheck in three hours. At 6:00 a.m., ULP contacted the nurse to report the resident's glucometer reading was still "high," he was lethargic, shaky and weak. The nurse directed ULP to call 911. The resident transferred to the hospital.

The resident's hospital notes indicated the resident was diagnosed with a heart attack, sepsis (a life threatening medical emergency caused by the body's extreme response to an infection) and diabetic ketoacidosis (a life threatening emergency complication of diabetes and high blood sugar levels).

A facility incident report indicated when questioned about missed medications and the missed insulin the night prior to the resident's hospitalization, ULP 2 said she administered the insulin and medications. She was unsure why it did not show up on the electronic MAR. ULP 2 was re-educated on medication administration and given a written warning for medication errors. The report failed to indicate the facility addressed failing to monitor the resident's blood sugars as prescribed and the medication error due to the transcription error that resulted in a low blood sugar.

The primary care provider listed in the resident's records reported to the investigator that the resident was not a patient of the clinic.

During an interview, a hospital medical provider stated the resident admitted to the hospital with a variety of medical issues that included a heart attack and poorly controlled diabetes. The medical provider stated it was hard to say if poorly controlled blood sugars caused cardiac issues since those issues co-occur. The medical provider stated people with poorly controlled blood sugars have heart attacks often. The medical provider stated the resident was at high risk as a type I diabetic.

During an interview, a nurse stated staff were trained at the corporate office, received shadow shifts with other staff, then had to complete competencies on medication administration, including insulin, before working independently. The nurse stated the nurse notified the resident's medical provider when they had high blood sugars per the providers orders. The nurse stated the facility did not manage sliding scale insulin orders, and a conversation was held with the medical provider to discontinue the resident's sliding scale orders while residing at the facility.

During an interview, ULP 1 stated caregivers were trained to follow each resident's electronic medication administration record on when to check blood sugars and how much insulin to give. ULP 1 stated if a resident had a very high blood sugar, she would give them water to drink and notify the nurse for further directive. ULP 1 stated she did not have any concerns or questions about the residents' insulin orders or administration. ULP 1 stated the resident received his insulin as ordered.

During an interview, ULP 2 stated she was trained by previous caregivers on how to give insulin. ULP 2 stated she did not receive training from a nurse and did not have to complete any competency on giving insulin. ULP 2 stated there was an issue where the electronic MAR did not save her recorded documentation due to a system syncing issue. ULP 2 stated she noted empty juice cups and other sugar snacks in the resident's room brought in by the resident's family member. The resident would have very high blood sugar from time to time.

During an interview, ULP 3 stated she received training at the licensee's corporate office and in person at the facility to give insulin. ULP 3 stated if a resident had low blood sugar, she called the nurse and gave the resident juice, peanut butter or sweets to help bring their sugar up. ULP 3 stated if a resident had high blood sugar, she gave them insulin, advised them to drink water, and called the nurse. ULP 3 stated the resident's insulin was available, and she did not have questions on how much insulin to give the resident since the order was very clear on how much to give. ULP 3 stated there was not a time she did not give the resident his insulin as ordered.

The resident could not complete an interview due to dementia.

During an interview, a family member stated the resident had several hospitalizations prior to admission to the facility. The family member stated the resident had used an insulin pump at home, but the facility advised they did not allow insulin pumps or sliding scale insulin orders at

the facility. The family member stated she did not know if the resident got his insulin or not as she was not always with the resident. The family member stated if staff had given the resident extra insulin, he would not have been hospitalized.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, unable to complete due to dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital for further evaluation when high blood sugar results were received.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40883	A. BUILDING: _____ B. WING _____	C 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARETTA SENIOR LIVING MAPLEWOOD LLC	1910 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL408831823C/HL408838702M On April 13, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 46 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL408831823C/HL408838702M , tag identification 730, 1760, 1960.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to include the correct name and contact number for the resident's medical provider in the resident's record, as required for 1 of 1 residents (R1) reviewed. This practice resulted in a level two violation {a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope {when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes type one diabetes, high cholesterol and high blood pressure. R1's service plan dated December 12, 2025, indicated R1 received assistance with oral medications four times daily, daily wellness checks, and insulin administration four times daily. R1's face sheet indicated medical doctor (MD)-A was R1's medical provider. The face sheet included a contact phone number for the provider. An email received on May 5, 02026, at 11:58 a.m., from the office of MD-A indicated it was	0 730		

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0 730	Continued From page 3 believed to be a clerical error to have MD-A listed on R1's face sheet as R1's provider while R1 resided with the licensee. The email indicated MD-A only managed patients at select facilities, and the licensee was not one of them. The email indicated it was believed the clerical error may have occurred if MD-A's name was carried over to R1's chart from a prior admission at a facility MD-A provided care at. TIME PERIOD FOR CORRECTION: Two (2) days	0 730		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to properly transcribe insulin orders and administer insulin correctly, as required for 1 of 1 residents (R1) reviewed. R1 received two types of insulin close time resulting in a low blood sugar. Additionally, R1 did not	01760		

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01760	Continued From page 4 receive scheduled long-acting insulin before bed and had a high blood sugar. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes type one diabetes, high cholesterol and high blood pressure. R1's service plan dated December 12, 2025, indicated R1 received assistance with oral medications four times daily, daily wellness checks, and insulin administration four times daily. R1's medication administration record (MAR) dated December 2025, indicated R1's short-acting insulin order dated effective as November 15, 2025, as inject 10 units subcutaneously three times daily before meals plus sliding scale. R1's hospital notes dated December 9, 2025, indicated the hospital changed R1's short-acting insulin order and decreased to inject 7 units of insulin three times daily before meals and included a sliding scale insulin order for additional insulin based on blood sugar test results. The orders indicated a new order to increase R1's long-acting insulin from 15 units to 20 units every night at bedtime. R1's progress notes dated December 9, 2025, at 1:05 p.m., indicated R1 returned to the facility.	01760		

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01760	Continued From page 5 The nurse contacted R1's provider to report the facility could not administer sliding scale insulin and the provider agreed to change the order. R1's MAR dated December 2025, indicated upon R1's return on December 9, 2025, R1 continued to receive the previous order of 10 units of short-acting insulin before supper at 4:30 p.m. On December 10, 205, R1 continued to receive the previous order of 10 units of shorting-acting insulin before breakfast and before lunch. The order was updated and transcribed to receive 7 units of short-acting insulin starting at 8:00 p.m. in error and failed to transcribe the short-acting insulin to be administered before supper as ordered. On December 10, 2025, R1 received in error short-acting insulin at 8:00 p.m., and the long-acting insulin at 9:00 p.m. R1's blood sugar record indicated the last recorded blood sugar on December 10, 2025 was 196 at 2:05 p.m. The licensee staff failed to check R1's blood sugar before supper and before bed. R1's progress notes dated December 11, 2025, indicated R1 had a low blood sugar of 57 at 4:36 a.m. and was shaking. Staff provided juice until R1's blood sugar returned to normal, 144, at 6:00 a.m. R1's MAR dated December 2025 indicated the long-acting insulin order was accurately transcribed on December 9, 2025 to receive 20 units and administered at 9:00 p.m. The order was stopped and then inaccurately transcribed to administer 22 units of long-acting insulin scheduled at 9:00 p.m. The MAR indicated R1 received 22 units of long-acting insulin in error on December 10 and	01760		

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01760	Continued From page 6 December 11, 2025. Staff failed to administer long-acting insulin on December 12, 2025. R1's progress noted dated December 13, 2025, indicated at 3:00 a.m., R1's glucometer reading was "high" (higher than what the glucometer was calibrated to read). The unlicensed personnel (ULP) reported to the nurse and directed to push fluids and recheck in three hours. At 6:00 a.m., R1's blood sugar reading was still "high" and staff sent R1 to the hospital. A facility incident report dated December 15, 2025, indicated when questioned about missed medications and the missed insulin the night prior to R1's hospitalization, ULP-B said she administered the insulin and medications. She was unsure why it did not show up on the electronic MAR. ULP-B was re-educated on medication administration and given a written warning for medication errors. The report failed to indicate the facility failed to identify and address the transcription error on December 10, 2025 that resulted in a low blood sugar and the transcription error of long-acting insulin instructing to administer 2 more units than ordered. During an interview on April 29, 2026, at 1:00 p.m., director of nursing (DON)-D stated she was not the DON at the time R1 received insulin and started in January 2026. DON-D stated if a resident does not receive a medication as ordered staff are to notify the nurse. The licensee policy titled, Medication Errors, last review date January 25, 2023, indicated medication errors included incorrect dosage given, a medication is skipped or given at the wrong time, or a medication is given that is not consistent with the prescription.	01760		

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01760	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to completed blood sugar checks as ordered for 1 of 1 residents (R1) reviewed. R1 experienced a hospitalization for an infection with insulin order changes. The licensee failed to complete scheduled blood sugar checks four times per day for two days aside from one check. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01960		

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01960	Continued From page 8 The findings include: R1's diagnosis includes type one diabetes, high cholesterol and high blood pressure. R1's service plan dated December 12, 2025, indicated R1 received assistance with oral medications four times daily, daily wellness checks, and insulin administration four times daily. A hospital discharge summary dated December 9, 2025, indicated an order to complete blood sugar monitoring before meals and at bedtime. The orders also included a decrease from 10 units to 7 units of R1's short-acting insulin scheduled three times per day before meals and an increase from 15 units to 20 units of R1's long-acting insulin scheduled at bedtime. R1's blood sugar record indicated the last recorded blood sugar on December 10, 2025 was 196 at 2:05 p.m. The licensee staff failed to check R1's blood sugar before supper and before bed. R1's progress notes dated December 11, 2025, indicated R1 had a low blood sugar of 57 at 4:36 a.m. and was shaking. Staff provided juice until R1's blood sugar returned to normal, 144, at 6:00 a.m. R1's medication administration record (MAR) dated December 2025, and blood sugar record indicated staff failed to completed all scheduled blood sugar checks (before meals and at bedtime) for R1 on December 11, 2025. R1's progress notes dated December 12, 2025, at 2:38 p.m., indicate the registered nurse (RN) spoke with R1's family who was upset about R1's blood sugar being 501. The family member was upset that R1's insulin was decreased to 7 units.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40883	A. BUILDING: _____ B. WING _____	C 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01960	Continued From page 9 The RN documented she sent a request to change the insulin dosage to R1's doctor. At 5:43 p.m., the doctor request a copy of R1's most recent glucose results, the RN documented she faxed the results to the doctor. R1's MAR dated December 2025, blood record indicated staff failed to completed blood sugar checks on December 12, 2025, at 8:00 a.m. and 12:00 p.m. Staff checked R1's blood sugar at 5:00 p.m. and it was 350. Staff failed to check R1's blood sugar at bedtime. The MAR indicated R1 also failed to receive his long-acting insulin at 9:00 p.m. on December 12, 2025. R1's progress notes dated December 13, 2025, at 2:55 a.m., indicated R1's blood sugar was noted "high" on the glucometer (higher than what the glucometer was calibrated to read). The notes indicated R1's blood sugar was rechecked at 5:58 a.m. and was noted to remain "high." R1 was sent to the hospital. R1's hospital record dated December 13, 2025, indicated R1 admitted to the hospital with a heart attack, sepsis (life-threatening, total body infection) and diabetic ketoacidosis (life-threatening complication when the body lacks enough insulin for energy). A facility incident report dated December 15, 2025, indicated the facility investigated missed bedtime medications on December 12, 2025, including the missed long-acting insulin. However, the report failed to indicate the facility addressed failing to monitor R1's blood sugars as prescribed. During an interview on April 29, 2026, at 1:00 p.m., director of nursing (DON)-D stated she was	01960		

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01960	Continued From page 10 not the DON at the time R1 received insulin and started in January 2026. DON-D stated unlicensed personnel are trained and competency tested to completed blood sugar checks and each resident had their own glucometers. During an interview on May 5, 2026, at 9:52 a.m., hospital medical doctor (MD)-F indicated R1 had type 1 diabetes that put him as a risk for heart attack with poorly controlled blood sugars. The licensee-provided policy titled Documentation of Medication, Treatment, and Therapy Management Services, dated August 1, 2021, indicated staff will document each task immediately, or as soon as reasonably possible, after the task had been performed. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		